MEDICARE AND THE GROUP HEALTH COOPERATIVE OF PUGET SOUND*

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I SHALL forego general comments on Medicare except to say that our Group Health Cooperative of Puget Sound, like The Kaiser Foundation Health Plan, Inc., supported the concept of Medicare not so much because of the needs of our own members, who were well provided for, but because of the needs of older people in general. We worked closely with other Group Practice prepayment plans to try to integrate such programs with Medicare legislation. I feel that Group Practice was only partly successful in achieving this goal; much remains to be done, especially in the fiscal area. However, let me tell you a little of what has happened in our project since Medicare. The Group Health Cooperative of Puget Sound is consumer-owned and has a nonprofit Group Practice prepayment plan that provides service to 105,000 people in the Puget Sound Area of western Washington. The cooperative employs more than 100 full-time physicians and operates a 170-bed hospital and four outpatient medical centers strategically located in and around Seattle.

About 7.5 per cent of its total enrollment consists of Medicare beneficiaries, compared with 10 per cent who are Medicare beneficiaries in the community at large.

Group Health has not tried to enroll additional Medicare subscribers. All members and subscribers are entitled to life-time coverage in our plan. Thus all we did at the time of Medicare was to alter our fiscal relations with our clients over 65 so that they could continue with us and yet derive maximum benefits from Medicare.

Group Health Cooperative is a single corporate entity. All facilities including the hospital are owned by the cooperative. Members of the medical staff, although they enjoy many of the advantages of a part-

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TABLE

Hospital days per 1,000 patients		*Percentage of total No. of beds used*
2,000/1,000	from	30% before Medicare
1,900/1,000	to	28% last half of 1966
1,800/1,000	to	24% at present

nership, are, technically speaking, employees of the cooperative.

For this reason our fiscal relation with Social Security is that of a *direct-dealing group practice plan.* Under Part B we receive a monthly capitation payment based on our estimated true costs for providing medical service. This is subject to audit and retrospective adjustment at the end of each fiscal period. Our hospital is paid on a standard per diem rate basis according to its operating costs. Reimbursement for our home health agency is split as care meets the definition under Part A and Part B of the law.

Like the Kaiser project, our plan since Medicare has had to increase substantially the incomes of physicians, nurses, and paramedical personnel. This caused substantial rises in operating costs.

People over 65 have not terminated their coverage with us because of Medicare. The percentage of our population over 65 has remained constant. These people have always enjoyed extremely broad benefits —even before Medicare—and their greatest fear at the time Medicare was enacted was that Group Health might abandon them. We have spent a great deal of time in attempting to reassure them by means of literature, meetings, and personal contacts that this would not happen.

Many of you may wonder why we do not actively enroll *more* Medicare clients. The answer is that we cannot develop additional hospital beds and clinical facilities fast enough to take care of additional old people, who use hospital beds at four times the normal rate and see the doctor about 1.6 times as often as the average subscriber.

Utilization of the services of doctors by people over 65 has remained relatively constant in comparison with that of the average client in our plan. Both the average client and the person over 65 are seeing the doctor more often than they did several years ago; however, the percentage of total doctor utilization has remained constant.

Utilization of hospital beds for acute illnesses has diminished, as shown in the accompanying table.

I believe this is largely due to the convalescent facility benefit, which was not available to our older people prior to Medicare.

Administratively our plan has had to make many adjustments because of our fiscal arrangement with social security. Our arrangement for reimbursement is quite different from our regular method of doing business and it is costly. We hope we can develop a new method of reimbursement based on a prospective capitation payment for both medical and hospital services. This would reduce administrative costs, and I am certain it would ultimately promote increased consciousness of cost and efficiency in the provision of medical care.